

1422 Partnerships and Collaborations

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July 19, 2017

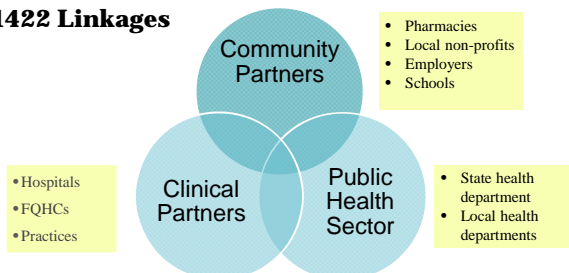


Outline

- 1422 network overview
- Maryland Office of Oral Health
- University of Baltimore Schaefer Center for Public Policy
- Questions/Discussion



1422 Linkages



1422 Communities

TODAY

- Allegany County/Garrett County
- Washington County
- Baltimore City

TOMORROW

- Caroline County/Dorchester County
- Somerset County/Wicomico County/Worcester County



Be Healthy Maryland Demo



HOME ABOUT CLASSES FIND CLASSES FOR PROVIDERS FOR PARTNERS QUESTIONS CONTACT US

Be Healthy Maryland

Find Classes to Help Create a Healthier Life

We're making changes to our website. Please take 1 minute to tell us what you like and what we need to improve. We are listening.

[Click Here To Help](#)

This website is for learning about and finding group classes to help create healthier lifestyles and manage day-to-day health. It is for people who have one or more health conditions.

These include pre-diabetics (being at risk of developing type 2 diabetes), diabetes, heart disease, high blood pressure, cancer, and many other long term conditions.

Click on About Classes to learn more about each type of class.

Do you want to refer a patient to a lifestyle change or self-management class?

Do you have questions about referring a patient to a lifestyle change or self-management classes?

Learn more about our partners who provide lifestyle change or self-management classes. This is also the place for our partners to find up to date news and information.


Find a class near you



Don't see a class in your area? Please let us know.



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MARYLAND
Department of Health

- My Workshops
- People
- Sites
- Workshops/Trainings
- Referring Entities
- Referring Individuals
- Referrals
- Participants
- Reports
- Import/Export

My Referrals | General | Environments | Due Dates | Content History | Print

New Referral
Referred On: []
Results: []
Curriculum: []
Workshop: [] Edit
Workshops shown in green have not started yet. No workshops available right now.
[]
Notes:
Save Changes Cancel Changes Add Referral Delete Referral



MARYLAND
Department of Health

First Name | Manage DPP Workshops

To manage a workshop, choose it from the list:

Jan 1, 2016—Demo Site—Diabetes Prevention Program
 Aug 1, 2017—Demo site2—Diabetes Prevention Program
 Sep 1, 2017—Demo Site—Diabetes Prevention Program
 Sep 15, 2017—Demo site2—Diabetes Prevention Program

☐ Include workshops which are completed

Then click the button: **Next >>**

First Name | Manage DPP Workshops

Enter the weight and activity information:

Session Type: **Core Session** Session Date: **Aug 24, 16**

First Name	Last Name	Email Address	Weight	Activity	Attended Session	Pregnant
Brenna	of Tark	Nobodybothersme@tark.com	239	150	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Demo Clema	Tyrell	QuenoThoma@edwyne.com	178	150	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Gregor	Clegane	gregor@honesrute.net	262	115	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Edal	Cheng	camuspenhupe@edtraki.com	328	150	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Lord	Varis	The Spider@MasterOfWhisperen	329	10	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Sam	Tarly	Maastensam@OOT.com	212	10	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Sansa	Stark	Sansa@winterscomeng.org	143	80	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Tormund	Gratibane	red@heefok.net	293	150	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Add Another Participant

Go Prev Save Changes

Import | Export

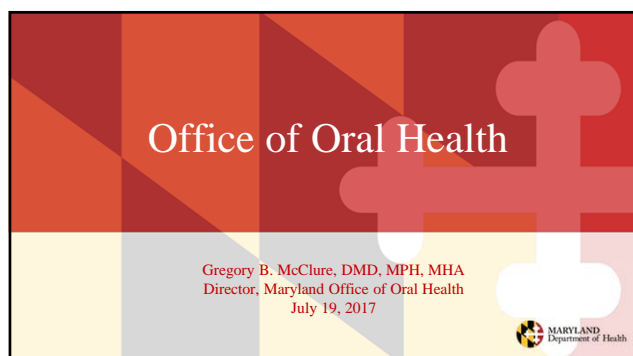
☒ Export DPP data to CDC

Organization: **Demo Organization**
 License Holder: **-AB-**
 Start Date: **6/1/16**
 End Date: **6/1/17**

Export

CDQReport.DPP - Excel

Participant	STATE	BLUETOOTH	DEM	WORKTEST	AGE	ETHNIC	ASIAN	BLACK	WHITE	SEX	WEIGHT	DATE	WEIGHT	PA
1	MD	1	1	1	27	2	2	2	2	1	2	16/1/2017	143	80
2	MD	1	1	1	27	2	2	2	2	1	2	16/1/2017	135	120
3	MD	1	1	1	27	2	2	2	2	1	2	16/1/2017	149	80
4	MD	1	1	1	27	2	2	2	2	1	2	16/1/2017	142	80
5	MD	1	1	1	27	2	2	2	2	1	2	16/1/2017	140	75
6	MD	1	1	1	27	2	2	2	2	1	2	16/1/2017	144	120
7	MD	1	1	1	27	2	2	2	2	1	2	16/1/2017	143	80
8	MD	1	1	1	27	2	2	2	2	1	2	16/1/2017	136	75
9	MD	1	1	1	27	2	2	2	2	1	2	16/1/2017	150	80
10	MD	1	1	1	27	2	2	2	2	1	2	16/1/2017	142	80
11	MD	1	1	1	27	2	2	2	2	1	2	16/1/2017	136	80
12	MD	1	1	1	27	2	2	2	2	1	2	16/1/2017	137	75
13	MD	1	1	1	27	2	2	2	2	1	2	16/1/2017	140	80
14	MD	1	1	1	27	2	2	2	2	1	2	16/1/2017	142	75
15	MD	1	1	1	27	2	2	2	2	1	2	16/1/2017	143	80
16	MD	1	1	1	27	2	2	2	2	1	2	16/1/2017	147	80
17	MD	1	1	1	27	2	2	2	2	1	2	16/1/2017	135	120
18	MD	1	1	1	27	2	2	2	2	1	2	16/1/2017	135	120
19	MD	1	1	1	27	2	2	2	2	1	2	16/1/2017	135	120
20	MD	1	1	1	27	2	2	2	2	1	2	16/1/2017	140	80
21	MD	1	1	1	27	2	2	2	2	1	2	16/1/2017	135	80



Oral Disease and General Health

- Dental Caries
- Periodontal Disease
- Oral Cancer
- HIV-AIDS
- Obesity
- Risk Factor
 - Cardiovascular Disease
 - Diabetes
 - Respiratory Disease
 - Stroke

Interprofessional Collaborative Practice

- When multiple health workers from different professional backgrounds work together with patients, families, and communities to deliver the highest quality of care. (WHO 2010)
- Integrate population health approaches across the health and partner professions so as to enhance collaboration for improving both individual care and population health outcomes.



Interprofessional Collaborative Practice

- Enabling framework for clinical care providers, public health practitioners, and professionals from other fields to collaborate more effectively and creatively across disciplines to optimize health care and advance population health.
- Better achieve the Triple Aim (improve the patient experience of care, improve the health of populations, and reduce the per capita cost of health care), with particular reference to population health.



Issues

- Rate of Undiagnosed Hypertension- 7.8% in USA
- 27 Million People Visit a Dentist and not a Physician Each Year
- Undiagnosed Diabetes-
 - 25%-33% of People with Diabetes
 - 86 Million Americans >Age 20 Have Prediabetes
- Dentistry and Medicine Have Historically Been Separated
- Removing Silos- Interprofessional Collaboration



Previous Oral Health and Chronic Disease Partnership

- Prediabetes and Oral Health Conference, July 2015
- Grant integration—1422
 - Local health departments engage oral health providers on diabetes prevention and hypertension
- Hypertension and Oral Health Conference, December 2016



CDC Cooperative Agreement 1307 9/1/2013 – 8/31/2018

- Five year cooperative agreement to enable states health departments to build and/or maintain effective public health programs
 - Program has two components:
 - Component 1 – Basic Capacity for Collective Impact (mainly for states that had not been previously funded)
 - Component 2 – Implementation of Evidence-based Community Preventive Interventions and Access to Clinical Preventive Services.



Models of Collaboration for State Chronic Disease and Oral Health Programs

- Awardees Select One Chronic Disease or Risk Behavior
- Implement Project of Mutual Importance to Oral Health and Chronic Disease Programs
- CDC Awarded Six States \$250,000
 - Alaska - Obesity/SSB
 - Colorado - Diabetes
 - Georgia - Tobacco
 - Maryland - Heart Disease/HBP
 - Minnesota - Heart Disease/HBP
 - New York - Obesity/SSB



Intent of the CDC
Models of Collaboration for State Chronic Disease
and Oral Health Programs Grant

- Partnership between Center for Chronic Disease Prevention and Control (CCDPC) and the Office of Oral Health (OOH)
- Facilitate the integration of oral health and chronic disease program activities, as well as engage oral health professionals to implement systems approaches to screen, counsel and refer patients for hypertension.
- Build on existing infrastructure and leveraging synergies with complementary programs and grants.



Maryland's Approach

Establish intradepartmental infrastructure and collaborate to:

1. Pilot a project to engage oral health professionals in blood pressure screening and referrals of patients with undiagnosed hypertension to primary care and community based resources
2. Establish a communication plan to improve messaging about the importance of oral health and the utilization of oral health professionals in chronic disease prevention and control
3. Establishment of an Advisory Panel to provide guidance on integration of oral health and chronic disease



Pilot Project

Engage all 1422 LHDs and identify an additional 3 LHDs to work with dental providers to:

- Implement policy and systems changes to screen patients for hypertension
- Educate patients on hypertension prevention and control lifestyle changes
- Refer patients to follow up care
- Recruit 2 Clinics Year 1; Additional 3 Year 2
- Evaluation Plan



Social Marketing Campaign

Goals:

- Facilitate collaboration between oral health and chronic disease
- Support systems change within dental and medical community
- Create awareness and facilitate hypertension screening at routine dental visits
- Increase understanding of the importance of hypertension control and management

Audiences:

- Dental patients (specifically those at risk for hypertension)
- Dentists, dental hygienists, dental assistance and dental office staff
- Primary care physicians and PCP office staff



Maryland's Long-Term Outcomes

- Oral health and Chronic disease program integration
- Increased proportion of adult smokers making quit attempts
- Improved prevention and control of hypertension
- Reduced prevalence of heart disease
- Sustained integration of oral health in chronic disease prevention and control
- Sustained collaboration between OOH and CCDPC
- Improved quality and lowered risk of complications in the provisions of dental care



Questions?



Building Partnerships for Healthy Communities

DR. AARON WACHHAUS
UNIVERSITY OF BALTIMORE
FELLOW, SCHAEFER CENTER FOR PUBLIC POLICY



Research Goals

- Map local healthcare networks
- Strengthen networks
- Assess collaboration in networks
- Increase collaboration



Timeline

Year 1	Cohort 1	Network analysis (5)
Year 2	Cohort 1	Assess collaboration (5)
	Cohort 2	Network analysis (7)
Year 3	Cohort 1	Assess collaboration (5)
Year 4	Cohort 1	Network analysis (5)



Methods

NETWORK ANALYSIS

1. Snowball survey
 - Identify network organizations
2. Network analysis survey

Surveys administered via Qualtrics

Network analysis via NodeXL

COLLABORATION

1. Wilder Collaboration Factors Inventory
 - Validated instrument
 - Assesses 20 factors influencing collaboration across 6 categories

Survey administered via Qualtrics



Scope of Study

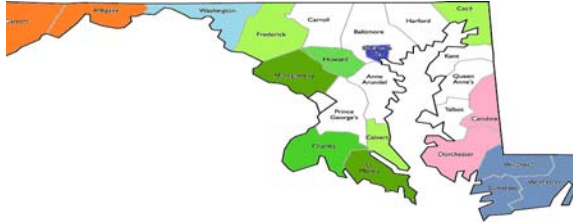
- 15 counties + Baltimore city
- 3252 surveys
- 938 network organizations identified
- 5173 linkages



Year 1 Networks



Year 1 & 2 Networks



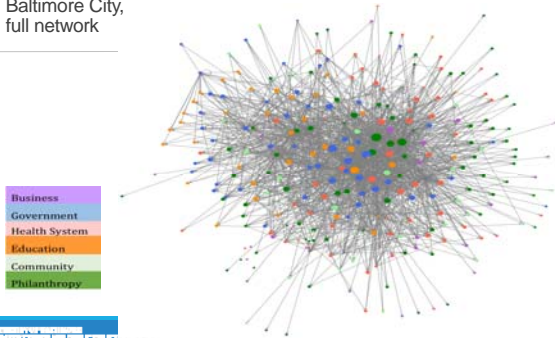
Network Organizations by Sector

Washington County		Western MD	
Business	18	Business	3
Government	11	Government	10
Health System	35	Health System	25
Education	8	Education	11
Community	12	Community	5
Philanthropy	15	Philanthropy	4
Total partners	99	Total partners	58

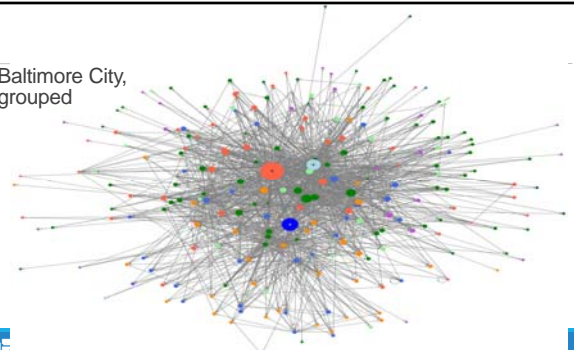
Baltimore City		Caroline & Dorchester	
Business	23	Business	3
Government	55	Government	16
Health System	62	Health System	17
Education	37	Education	10
Community	27	Community	9
Philanthropy	83	Philanthropy	26
Total partners	287	Total partners	81

Lower Shore	
Business	10
Government	24
Health System	12
Education	8
Community	7
Philanthropy	7
Total partners	68

Baltimore City, full network



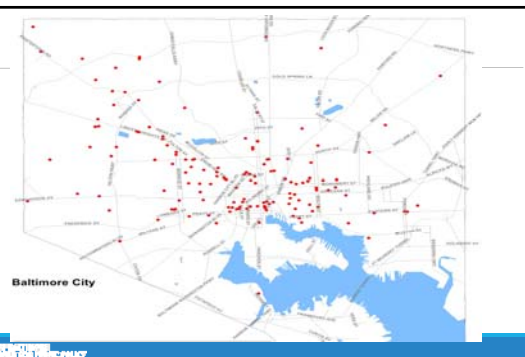
Baltimore City, grouped



Baltimore City, reciprocal partners

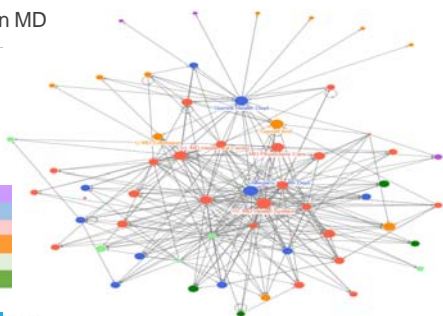


Baltimore City

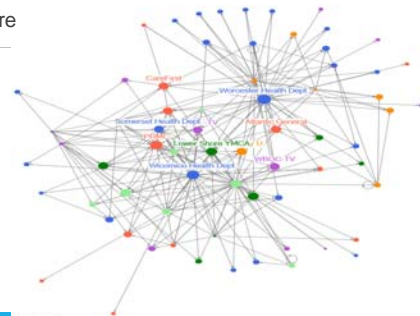


Western MD

Business
Government
Health System
Education
Community
Philanthropy



Lower Shore



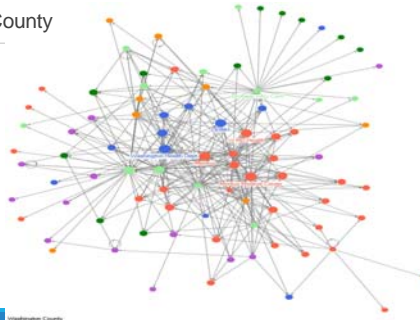
Caroline & Dorchester counties



Category	Factor	Score
Environment	History of collaboration or cooperation	4.03
	Network seen as a legitimate leader in the community	3.80
Member characteristics	Mutual respect, understanding, and trust	3.83
	Appropriate cross section of members	3.47
	Members see collaboration as in their self-interest	4.22
Process & Structure	Members share a stake in both process and outcome	3.57
	Flexibility	3.89
	Development of clear roles and policy guidelines	3.47
	Adaptability	3.67
Communication	Appropriate pace of development	3.30
	Open and frequent communication	3.80
	Established informal relationships and communication links	3.87
Purpose	Concrete, attainable goals and objectives	3.65
	Shared vision	3.52
	Unique purpose	3.35
Resources	Sufficient funds, staff, materials, and time	2.98

Factor	Highly central	Peripheral	Overall Score
History of collaboration or cooperation	4.25	3.95	4.03
Network seen as a legitimate leader in the community	4.00	3.73	3.80
Mutual respect, understanding, and trust	3.88	3.82	3.83
Appropriate cross section of members	3.13	3.59	3.47
Members see collaboration as in their self-interest	4.50	4.11	4.22
Members share a stake in both process and outcome	3.44	3.63	3.57
Flexibility	3.75	3.95	3.89
Development of clear roles and policy guidelines	3.33	3.53	3.47
Adaptability	3.88	3.58	3.67
Appropriate pace of development	3.29	3.31	3.30
Open and frequent communication	3.57	3.90	3.80
Established informal relationships & communication links	4.07	3.78	3.87
Concrete, attainable goals and objectives	3.62	3.67	3.65
Shared vision	3.71	3.44	3.52
Unique purpose	3.43	3.31	3.35
Sufficient funds, staff, materials, and time	2.93	3.00	2.98

Washington County



Conclusions

STRENGTHS

- Buy-in from partner organizations
- Community legitimacy
- Robust, multi-sector partnerships

RECOMMENDATIONS

- Increase awareness of network & partners
- Target resources to networks
- Develop network management strategy
- Manage membership & turnover



QUESTIONS?

